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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

PRISCILLA SAENZ, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF CARMEN SAENZ, DECEASED,
Petitioner,
v.
HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION RESTATED

Should the Petition be granted to review the Fifth Circuit Court of Appeals' holding that the Federal Employee Health Benefits Act's preemption provision, 5 U.S.C. 8902(m)(1), preempts petitioner's state law claims?

STATEMENT REQUIRED BY RULE 29.6

The parent company of Humana Health Plan of Texas, Inc. d/b/a Humana Health Plan of Corpus Christi is Humana, Inc. Humana, Inc. has no parent company. Neither entity has any non-wholly owned subsidiaries.

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HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF CORPUS CHRISTI AND HUMANA, INC.,
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RESPONDENTS' BRIEF IN OPPOSITION

Petitioner, Priscilla Saenz, As Personal Representative of the Estate of Carmen Saenz, Deceased ("Saenz"), seeks review of a decision of the United States Court of Appeals for the Fifth Circuit in *Saenz v. Humana Health Plan of Texas, Inc. et al.*, No. 96-40111 (5th Cir. Dec. 12, 1996) (per curiam), *petition for cert. filed*, 65 U.S.L.W. 41 (U.S. Apr. 10, 1997) (No. 96-1618).[1] By its decision,

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[1] All references to Petitioner's Petition for Writ of Certiorari will be cited as "Pet.", e.g., "Pet. 1". For the convenience of the Court, all citations to the Fifth Circuit's opinion below are contained in the Petition's Appendix and cited as "Pet. App.", e.g., "Pet. App. 1". All references to the Appellate Record are referenced with the term "Rec.", e.g., "Rec. Vol. 1, p. 1".

the Fifth Circuit upheld a summary judgment denying Saenz's claims which arise out of certain health benefits sought by Carmen Saenz from her health plan, Humana Health Plan of Texas, Inc. d/b/a Humana Health Plan of Corpus Christi ("Humana Health"). In light of the misstatement of facts by the petitioner and her heavy reliance upon factual allegations from the trial pleadings which are unsubstantiated by the record, respondents provide the following Counterstatement.

COUNTERSTATEMENT OF THE CASE

Carmen Saenz, a federal employee in Corpus Christi, Texas, was a member of a health maintenance organization ("HMO") offered by Humana Health to federal employees. Under the Federal Employee Health Benefit Act (FEHBA), 5 U.S.C. 8901, *et seq.*, Humana Health contracts with the United States Office of Personnel Management ("OPM") to provide a medical plan to federal employees such as Ms. Saenz. Rec. Vol. 2, pp. 314-316. The HMO and Ms. Saenz's relationship was generally governed by a 20 page contract (the "Plan Document"). Rec. Vol. 2, pp. 509-529 & 540-560. As set forth in the Plan Document, Humana Health's HMO "arranges in advance with specific doctors and hospitals to give care to members and pays them directly for their services." For Ms. Saenz's medical care to be covered under the HMO, she had to obtain medical care from "Plan providers except in a medical emergency". The Plan also required that the participant's primary care physician request preauthorization from Humana Health prior to any hospitalization or referral to a specialist. Rec. Vol. 2, pp. 514 & 515.

In this case, on September 2, 1993 (not the summer of 1993 as petitioner states), Ms. Saenz's primary care physician requested pre-authorization for admission of Ms. Saenz to The University of Texas M.D. Anderson Cancer Center in Houton, Texas. Houston is over 150 miles from Corpus Christi and is outside of Ms. Saenz's plan's pro-

vider network. As a result, Humana Health denied Ms. Saenz coverage for a proposed September 15, 1993 admission to M.D. Anderson. Rec. Vol. 2, p. 571. The denial was made promptly and was explained in a September 15, 1993 letter to Ms. Saenz by Humana Health's medical director. As noted in the letter, it was the medical director's understanding that cancer specialists in the health plan's provider network could provide Ms. Saenz the care she needed. Rec. Vol. 2, p. 277. Despite Humana Health's denial of benefits, Ms. Saenz opted to proceed with the chemotherapy treatment scheduled at M.D. Anderson. Rec. Vol. 2, p. 572. She continued to receive treatment at M.D. Anderson as late as 1995, and testified she did not discontinue any cancer therapy at M.D. Anderson because Humana Health was not paying. Rec. Vol. 2, pp. 576-580 & 629.

Under Ms. Saenz's FEHBA health plan, she had the right to request reconsideration by Humana Health of the denial of benefits and, ultimately, she could appeal the denial to OPM, the agency empowered to reverse decisions of the health plan. Rec. Vol. 2, p. 526. Ms. Saenz did in fact request reconsideration by Humana Health and eventually appealed the denial to OPM. On August 22, 1994, based on newly discovered information, Humana Health reversed its initial denial and authorized payment to M.D. Anderson. Rec. Vol. 2, p. 572. Humana proceeded to pay M.D. Anderson and other related providers covered charges of $51,715 for services dating back as far as September 16, 1993. In light of Humana Health's reversal of its denial of the benefits of Ms. Saenz's chemotherapy treatment at M.D. Anderson, OPM completed its review of Carmen Saenz's appeal. Rec. Vol. 2, p. 582.

Under the Plan Document approved by OPM, any dispute regarding the Plan's "benefits or coverage or payments with respect to those benefits", is governed by federal law. As OPM has the power to reverse Humana Health's denial, judicial review of any matter that relates to benefits, coverage or payment of benefits is limited to

a review of a final decision of OPM. Under the Plan Document, a claimant's recovery in such a lawsuit is limited to "contract benefits in dispute, plus simple pre-judgment interest . . . and court costs." Rec. Vol. 2, p. 526.

Despite the fact that the covered benefits had been paid, and contrary to the provisions of the Plan Document governing the relationship between Saenz and Humana Health, Saenz instituted suit in a Texas state court on December 21, 1994 alleging that "Humana refused to pay" for treatment at M.D. Anderson and that it breached "its obligations under the Plan". Based on this alleged breach and refusal to pay, Saenz also asserted extra-contractual bad faith claims and sought damages other than those allowed under the Plan Document. Humana Health answered stating that all of Saenz's claims were preempted by virtue of FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1). Rec. Vol. 3, pp. 1169-1183. Humana Health then removed the case to U.S. District Court and sought dismissal of all of Saenz's claims by a Motion to Dismiss and a Motion for Summary Judgment. The Court permitted Saenz to amend her pleadings to which she responded by enlarging her pleading to contain a number of additional extra-contractual claims as well as a claim under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961-1968. Rec. Vol. 2, pp. 676-706. Saenz also named Humana, Inc., Humana Health's parent company, as a party Defendant.

The U.S. District Court, after considering Defendants' Amended Motion to Dismiss and Motion for Summary Judgment, held that "[t]he Plaintiff's state law claims arise from Defendants' delay in payment of benefits, and are therefore 'inconsistent' with contractual provisions of the Plan." As such, the Court granted summary judgment against Saenz on all her state law claims. The Court also granted Humana's Motion for Summary Judgment on Plaintiff's RICO claim. Pet. App. 13.

During the pendency of the case, Carmen Saenz died and her daughter, Priscilla Saenz, substituted in to represent her interest in the case. Priscilla Saenz sought appeal of the case to the U.S. Court of Appeals for the Fifth Circuit. Briefs were submitted by the parties and, on December 12, 1996, nine days after oral argument, the court of appeals affirmed by per curiam opinion the U.S. District Court's holding.

In her Statement of the Case, petitioner summarizes a number of *alleged* acts (*See* Pet. 5-6) which are not supported by the summary judgment proof, are factually incorrect, and constitute misrepresentations to which objection is made pursuant to Supreme Court Rule 15.2. Further, regardless of the preemption of the claims, the allegations fail to provide a basis for any claim and are merely an attempt to disparage the respondents by false statements and innuendos of malfeasance. The record contains no evidence to support the allegations pled, as required in the face of the Humana Defendants' Motion for Summary Judgment,[2] and, as they are offered as statements of fact, they are denied. For example, Humana did not represent that it would provide "the best of health care" and the comparison of this statement to the testimony within the deposition of the health plan executive director (which is not within the record) is incorrect and misleading. Second, the medical director for the health

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[2] Respondents sought and obtained dismissal in the district court pursuant to Federal Rule of Civil Procedure 12(b)(6) (dismissal for "failure to state a claim upon which relief may be granted") and Rule 56 (dismissal by summary judgment). The district court granted Summary Judgment based on preemption of the state law claims alleged. While many of the factually incorrect pleadings, even taken as true, do not support the elements of a cause of action, they are addressed herein to the extent they are relevant to an alternative motion for summary Judgment claim sought in the district court because petitioner cannot support the elements of her causes of action under *Celotex Corp. v. Katrett*, 477 U.S. 321 (1986).

plan did not admit "lying" to Carmen Saenz about the treatment to be received and no evidence in the record presented even implies such an action. Third, no evidence is provided that Humana Health gave incentives to primary care physicians to avoid hospitalization of HMO members. This issue is not determinative of any element of petitioner's claim nor is it factually correct. Any financial incentives given to a primary care physician in this area is provided to ensure referrals are made efficiently and effectively, not to deter the hospitalization of patients that need hospitalization. Fourth, petitioner's allegation that Humana Health requires primary care physicians to perform services they are not qualified to do is a misstatement. As noted in the Plan Document, the primary care doctor will refer, when necessary, the participant to specialists. The requirement that a primary care physician make the referral to the specialist was disclosed at numerous points in the Plan Document. Rec. Vol. 2, pp. 514, 515 & 528. Therefore, this contention provides no support for the ultimate contention made in petitioner's Statement of Facts that Carmen Saenz would not have become a member of the health plan if she had known that she would have to receive a referral from a primary care physician before she went to an oncologist. The Plan Document clearly sets forth this information and there is no evidence in the record to the contrary. Fifth, there is nothing in the record to substantiate petitioner's statement that Humana in any way refused to disclose the name of any physicians who reviewed whether the treatment could be provided in the network. Sixth, as for the moving of Ms. Saenz to a nursing home during the period that the orthopedic surgeon had to wait for a particular hip pin to be delivered, there is no credible evidence within the record that it was inappropriate for Ms. Saenz to move to a nursing facility while she was waiting for the hip pin. Additionally, the treating physician made the referral of the patient to the nursing home and Humana Health pro-

vided benefits for that service. Accordingly, petitioner's statement is a mischaracterization of the facts in the case. Regardless, as will be addressed, these unsubstantiated allegations are a passel of red herrings alleged in the trial court, not as the true complaint of petitioner, but as a desperate attempt to "muddy the water" to save the case from dismissal.

REASONS FOR DENYING THE WRIT

I. THE OVERWHELMING WEIGHT OF AUTHORITY SUPPORTS THE FIFTH CIRCUIT'S HOLDING THAT FEHBA PREEMPTS PETITIONERS' STATE LAW CLAIMS.

Saenz's petition should be denied for the same reasons that this Court denied the petition for writ of certiorari in *Hayes v. Prudential Ins. Co. of America*, 819 F.2d 921 (9th Cir. 1987) *cert. denied*, 484 U.S. 1060 (1988), approximately nine years ago. Just as the insured did in *Hayes*, petitioner urges that her claims of bad faith and unfair dealing, fraudulent inducement, deceptive trade practices and violations of the Texas Insurance Code are not preempted by the FEHBA preemption provision, 5 U.S.C. § 8902(m)(1). In *Hayes*, the Ninth Circuit held that all of these causes of action, as well as breach of contract, civil conspiracy, and breach of fiduciary duty, are preempted under FEHBA. *Id.* at 926. Since the time that this Court denied the petition for writ of certiorari in *Hayes*, Congress has not amended FEHBA's preemption provision nor has this Court or a United States Court of Appeals held that similar claims of health plan participants are not preempted.

Three United States Court of Appeals have *directly* addressed the issue requested to be reviewed by Saenz, and have held FEHBA preempts a plan participant's extra-contractual state law claims. *See Hayes, supra*; *Burkey v. Government Employees Hospital Ass'n.*, 983 F.2d 656, 657-58 (5th Cir. 1993) (claim for doube dam-

ages and attorney's fees for unreasonable delay in paying health and accident insurance claims under Louisiana law held to be preempted by FEHBA); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (health plan participants' bad faith claim against health insurer under South Carolina law held to be preempted by FEHBA). In addition to the foregoing, in the other courts of appeals cases addressing FEHBA preemption, three other courts have held FEHBA preempts all state law claims presented in those respective cases. *See Harris v. Mutual of Omaha Cos.*, 992 F.2d 706, 711-12 fn. 1 (7th Cir. 1993) (due to FEHBA preemption, federal law controls over Indiana law in the interpretation of health insurance contract); *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 806 (8th Cir. 1993) (FEHBA preemption provision mandates that FEHBA health plan has the preemptive force of federal law); *Blue Cross and Blue Shield v. Florida Department of Banking*, 791 F.2d 1501, 1505 (11th Cir. 1986) (due to FEHBA preemption, health plan's contract preempts Florida state law); *Tackitt v. Prudential Ins. Co. of America*, 758 F.2d 1572, 1575 (11th Cir. 1985) (interpretation of right to home health care benefits under a FEHBA contract is controlled by federal and not state law due to FEHBA preemption); *see also Caudill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74, 79 (4th Cir. 1993) (while not relying on the FEHBA preemption provision, federal common law held to entirely replace state contract law in the interpretation of a FEHBA health plan).

In an attempt to convince this Court to consider granting her petition, Saenz states that there is a "conflict in the opinions of various appellate courts" on the issue ruled on by the Fifth Circuit below that FEHBA preempts all of petitioner's state law claims. Pet. 2. Later in her petition, however, Saenz states, "[t]o date, the ruling of the lower courts, with one exception, have been that every state court cause of action brought to their attention in a FEHBA case has been preempted." Pet. 18. Petitioner

then cites the "one exception", *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), which, while peripherally addressing FEHBA preemption, did not directly address the issue of whether state law contractual and extra-contractual claims are preempted by FEHBA. The Tenth Circuit in *Howard* primarily addressed whether the court had jurisdiction to hear the case under federal common law and, in finding that it did not, cited Section 8902(m)(1) in a footnote and noted only that "there is no indication" that an Oklahoma law conflicts with the health plan contract. *Howard*, 739 F.2d at 1510. Accordingly, *Howard* is not a case which supposedly creates a conflict of "various federal appellate courts" as cited by petitioner.[3]

Even if *Howard* could be considered "a conflicting opinion", it was rendered before the other opinions reviewing FEHBA preemption, it did not directly address the issues before the Fifth Circuit in *Saenz*, and it is contrary to the holdings of six other United States courts of appeals. In light of the precedent of the numerous circuit courts, as well as the denial of a previous petition for writ of certiorari in *Hayes*, petitioner's request for review by this Court serves only to prolong litigation over an issue wherein numerous courts have exhaustively analyzed FEHBA preemption and have generally arrived at the same conclusion: FEHBA health plans preempt state law contract and extra-contractual claims. In light of the filing of the petition, however, respondents will again address the issues raised before the lower courts.

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[3] The Fifth Circuit in *Burkey*, when surveying the opinions which hold FEHBA preempts state law claims, did acknowledge one circuit "held otherwise", referring to *Howard*. *Burkey*, 983 F.2d at 659. In doing so, howeevr, the court spoke in general terms and did not review the *Howard* opinion in depth. *Howard's* lack of any strong reliance on the interpretation of FEHBA's preemption provision reveals that it is hardly a conflicting opinion.

II. THE FIFTH CIRCUIT PROPERLY CONSTRUED THAT CONGRESS' INTENT IN ENACTING FEHBA'S PREEMPTION PROVISION WAS TO INSURE UNIFORMITY IN THE ADMINISTRATION OF FEDERAL EMPLOYEE HEALTH BENEFITS.

A. Legislative History and Statutory Language.

Petitioner basically contends that FEHBA's preemption provision has been misconstrued by the numerous appellate courts which have determined its scope. Petitioner contends that the courts are wrong in their analysis, arguing that FEHBA preemption is limited to contract claims and that it does not cover extra-contractual claims. Petitioner, however, ignores the legislative history relied on by the Fifth Circuit in *Saenz* and the other cases which have analyzed the breadth of FEHBA preemption.

In 1978, Congress amended FEHBA to include a preemption provision. By the preemption provision, the provisions of any FEHBA contract "which relate to the nature or extent of coverage or benefits" supersede and preempt any state laws inconsistent with the provisions of the contract. 5 U.S.C. § 8902(m)(1). Recognizing that a "program established by an act of Congress [ ] should not be subject to alterations or regulations by State legislatures or State insurance boards," H.R. Rep. No. 282, 95th Cong., 1st Sess. 4 (1977), Congress enacted § 8902(m)(1) for the sole "purpose of . . . establish[ing] uniformity in benefits and coverage under the Federal Employee's Health Benefits Program." S. Rep. No. 903, 95th Cong., 2nd Sess. 2, *reprinted in* [1978] U.S. Code Cong. & Admin. News 1413. Relying on Congress' specific intent to "ensure nationwide uniformity of the administration of FEHBA benefits," numerous cases have held FEHBA contracts preempt state law claims of health plan participants. *Burkey*, 983 S.W.2d at 660 (citing cases relying on Congress' intent to provide uniformity).

The construction given the preemption provision by the majority of courts construing the provision is consistent

with Congress' intent when it authorized the federal government to wade into the area of the administration of group health benefits for government employees. In the creation of the right of federal employees to join a health plan which provides benefits at a cost "generally charged for new group health benefit plans issued to large employers" in the private sector, 5 U.S.C. § 8902(i), checks and balances were built into the entire statute and regulatory process governing most every area of the administration of benefits to federal employees. For example, Humana Health must adhere to FEHBA and OPM contract requirements such as: (1) any brochure regarding benefits of Humana Health has to be approved by OPM; (2) if Humana Health does not maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet the obligations of a FEHBA contract, it may be suspended by decision of OPM; (3) Humana Health ceded all final decision making on disputed claims to OPM pursuant to 5 U.S.C. § 8902(j); (4) Humana Health agreed to provide benefits to federal employees at a rate equivalent to "that charged to the total community rated membership of the carrier", that is, health plans offered to employees in the private sector; (5) Humana Health must submit to OPM for "prior approval" any supplemental literature to be distributed at federal facilities to determine whether it is in compliance with FEHBA regulations as to misleading, deceptive, or unfair advertising; and (6) Humana Health must allow federal employees to enroll in the plan regardless of preexisting conditions under 5 U.S.C. § 8902(f). Rec. Vol. 2, pp. 319, 320, 322, 328, 329, 408A, & 446.

Also, numerous regulations govern the relationship between OPM, the health plan and the federal employee as promulgated under the authority granted to OPM by Congress in 5 U.S.C. 8913. *See* 5 C.F.R. 890 *et seq.* Under the administrative process, Congress delegated to OPM the authority to interpret health benefit contracts and, as stated, to make the final decision regarding whether bene-

fits should be paid or not. As noted by the Fifth Circuit in its opinion in *Saenz*,

> OPM provides a procedure for review of claims, denials and delays and the imposition of liability under a state cause of action based on the reasonableness of a claim denial cannot avoid duplication of and conflict with OPM review.

Pet. App. 7. Congress' intent to preempt state laws such as those giving rise to the claims in *Saenz* (as well as the other cases cited above), is clearly indicated by the creation of the preemption provision and the OPM review process. What Saenz proposes, to limit preemption to claims for actual benefits and allow a second avenue for relief through the state courts on extra-contractual claims, would render Congress' enactment of the preemption provision meaningless. To allow the adjudication of extra-contractual claims would foster interstate rivalries in coverage by subjecting different federal employees to differing rights and remedies. If Saenz's proposal were adopted, the uniformity envisioned by Congress would be wholly defeated.

B. FEHBA Plan's Language and Preemption.

Saenz urges this Court to review FEHBA's preemption provision and specifically its "inconsistent with" language. In support of this request, Saenz states "no federal appellate court has considered to what extent state laws . . . are or could be inconsistent with the language of an insurance policy. . ." Pet. 28-29. This is a misstatement. In *Hayes v. Prudential Life Ins. Co. of America*, the court expressly held that state law claims which "invariably expand [the health plan's] obligations under the terms of the Plan . . . are *inconsistent with the Plan* and, hence, preempted under § 8902(m)(1)." *Hayes*, 819 F.2d at 926 (emphasis added).

Petitioner then proceeds to lead the Court through a series of mental gymnastics by comparing provisions of

the Plan Document and ignoring the policy stated in *Hayes* that state laws which enlarge the plan are inconsistent with it and, therefore, are preempted. For example, Saenz urges that because the Plan Document does not expressly permit bad faith and fraud, the contract is not "inconsistent with" state laws forbidding bad faith and fraud. Pet. 12. The "inconsistent with" language within the preemption provision, however, does not require the Plan Document to be an endless compilation of terms permitting certain actions which otherwise are forbidden by state statutes. The intention of the Plan Document is to set forth the general provisions of how the benefits are to be administered by the health plan and to be received by the federal employee. This ignores the previous holdings and the logical premise that allowing extra-contractual claims would only serve to expand the obligations of the carrier under the agreement and they would, therefore, be "inconsistent with" the terms of the plan.

Saenz tries another angle supposedly supporting her position by posing the question of what would happen if the health plan medical director unilaterally denies a claim, not based on the prevailing medical science at the time, but rather based on an unsubstantiated medical belief and thereby modifies the plan's obligation to follow generally accepted medical practice? Pet. 14-15. Saenz proposes that if Humana Health can modify the plan, then Saenz should likewise have the right to pursue a bad faith claim for an unjustified denial of benefits. These examples, like wild swings late in a prize fight, fail to hit the intended target. Saenz attempts to create rights in the agreement which are not evident from the agreement's terms and are inconsistent with the express terms of the Plan Document, the FEHBA statute, and OPM regulations. For instance, in the event the medical director failed to consider generally accepted medical practice in making a denial, the federal employee could immediately pursue his right to OPM review of the medical director's decision based on the rights set forth on page 18 of the Plan Document. By statute, OPM is vested with the

power to ensure that the federal employee receives the health service he "is entitled thereto under the contract." 5 U.S.C. § 8902(j). As such, if the medical director is wrong, OPM can order benefits to be paid. Therefore, the express provisions of the plan provide a remedy to the plan participant and the plan is not "modified" as suggested by Saenz.

In an attempt to show that her extra-contractual claims are not "inconsistent with" the contract, Saenz also refers the Court to the provisions in the Plan Document which state that (1) it is a criminal act for the participant to submit fraudulent claims and (2) the participant is to submit claims promptly for them to be considered. Pet. 11-12. Saenz appears to be contending that this language is support for her position that state laws which forbid fraud and bad faith are consistent with these plan provisions and are, therefore, not preempted. This argument ignores the provision of the Plan Document which states "[f]ederal law exclusively governs all claims for relief in a lawsuit that relate to this plan's benefits or coverage or payments with respect to those benefits." Rec. Vol. 2, p. 526. Consistent with Congress' intent, the only lawsuit which may be pursued is an appeal of OPM's final decision. Saenz argument, if carried to its illogical conclusion, would actually create a right of action which is inconsistent with the terms on page 18 of the Plan which (1) require OPM review, (2) limit lawsuits to judicial review of OPM's decision, and (3) limit damages in such actions to plan benefits, interests and court costs.

Petitioner also attempts to provide a restrictive interpretation of the Plan Document's dispute provisions on page 18 by stating that they only envision review of benefit disputes—not extra-contractual claims. Pet. 16-17. Again, petitioner misleads the Court by ignoring the express terms of the Plan Document which state: "Federal law exclusively governs *all* claims for relief in a lawsuit that *relate to* this Plan's benefits or *coverage or payment* with respect to those benefits." Rec. Vol. 2,

p. 526 (emphasis added). The foregoing language from the Plan Document tracks the terms of the FEHBA preemption provision. Plainly, this language is not limited to just the benefit determination but *also* issues which "relate to" benefits, coverage and payments. Like ERISA's preemption provision (which also contains the term "relate to"), the Plan Document and FEHBA's "relate to" phrase has been held to be determinative of the breadth of preemption. As noted in *Blue Cross and Blue Shield v. Florida Department of Banking*, 791 F.2d 1501, 1505 (11th Cir. 1986), like ERISA's use of the phrse "relate to",[4] FEHBA's use of the term "relate to" is similarly to be interpreted liberally to include state laws which have "any connection with or reference to such insurance or plans." Accordingly, Saenz's attempt to narrow the scope of FEHBA preemption by citing phrases of the plan's dispute provisions out of context fails when the light of day is put on the rest of the language of the provisions.

Saenz persists in her claim that, under the FEHBA preemption provision and the terms of the contract, Congress intended only for the right to benefits to be determined by OPM and that only contract benefits claims are preempted. Pet. 16-17. Saenz makes this argument urging that extra-contractual claims, such as bad faith, survive preemption as they are not expressly subject to OPM review. Saenz basically claims that preemption flows only to the benefit claim, a contract claim, and, thus, preemption of a benefit claim does not necessarily include the bad faith claim. This theory was rejected by this Court

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[4] In *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), this Court reviewed ERISA's preemption provision which provides that ERISA preempts "any and all state law insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court determined that it "must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning." *Id.* at 96-97. The holding went on further to find that the term "relate to" means a state law is preempted "if it has a connection with or reference to such a plan."

in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 200 (1985). *Allis-Chalmers* analyzed the applicability of the Labor Management Relations Act of 1947 (LMRA), 29 U.S.C. § 185, to the denial of an employee's health benefit claim. *Id.* at 206. The LMRA also has a preemption provision and requires that disputes be submitted to a grievance procedure before a lawsuit can be commenced. *Id.* Lueck skipped any grievance procedures and filed suit in state court alleging state law bad faith claims and seeking extra-contractual damages. The Wisconsin Supreme Court held that the LMRA did not preempt Lueck's bad faith claims because, "though a breach of duty exists as a consequence of the relationship established by contract, [the bad faith claim] is independent of that contract." *Id.* at 207. This Court reversed and held Lueck's bad faith claim was preempted stating that "[t]he duties imposed and rights established through the state tort thus derive from the rights and obligations established by the contract." *Id.* at 217. As such, "[s]ince the state tort purports to give life to [the contract] terms in a different environment, it is preempted." *Id.* at 219. *Allis-Chalmers*' reasoning was relied on heavily in *Hayes* and *Burkey* for this same proposition as applied in the FEHBA scenario. *See Burkey*, 983 F.2d at 660; *Hayes*, 818 F.2d at 926; *see also Saenz*, Pet. App. 6.

Despite the previous rulings of *Hayes*, *Burkey*, and the Fifth Circuit below, Saenz contends that the bad faith claims are separate and apart from the contract claim. The same concern in *Allis-Chalmers* about the effect of finding a bad faith claim to not be preempted holds true in *Saenz*. While in *Allis-Chalmers* it is the arbitrator's role which is rendered meaningless by an employee restating his contract claim in the form of a tort claim, in *Saenz*, it is OPM which will be bypassed by a government employee doing the same, thereby defeating the purpose of having nationwide uniformity of the administration of FEHBA benefits. This Court's express position in *Allis-Chalmers* relates directly to the same issues

raised by *Saenz* and, as such, petitioner's claims of a dual remedy, one outside OPM and one under state law, if adopted, would render Congress' action in creating FEHBA's safeguards and preemption meaningless.

Saenz similarly contends that the appeal right of a participant to OPM does not provide a sufficient remedy and then sets forth the implausible example of an AIDS patient whose claim is "unjustifiably denied" because his insurer believed he would not have "sufficient resources" to pursue a claim before he died. Pet. 22. As noted in *Kobleur v. Group Hospitalization & Med. Services*, 954 F.2d 705, 711 (11th Cir. 1992), the delegation of authority to OPM to review denied claims is proof of "Congress' faith in OPM's ability to protect federal employees through its administration of the program." Therefore, the relief necessary to protect the government employee, as determined by Congress, is available in the power of OPM to unilaterally review and, if necessary, reverse a health plan's denial.

C. Comparison of FEHBA to Other Statutes.

Saenz attempts to compare the Americans With Disability Act (ADA), 42 U.S.C. § 12101, *et seq.* and the "Civil Rights Act of 1964, 29 U.S.C. § 1001, *et seq.* [sic]" [5] to FEHBA contending Congress could not have possibly intended to allow for extra-contractual damages under the Civil Rights Act and the ADA and afford something less to federal employees denied health benefits. Pet. 24-25. This argument ignores that Congress specifically afforded a complaining party under the ADA and the Civil Rights Act the right to "recover compensatory and punitive damages" by statute. 42 U.S.C. 1981a(a)(1). No similar provision can be found within FEHBA. In essence, Saenz is urging this Court to substitute its judg-

[5] Petitioner is apparently referring to the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* (as amended by the Civil Rights Act of 1991, 42 U.S.C. 1981a).

ment for that of Congress and to disregard what Congress has intentionally provided within the plain meaning of the statute. Of course, it is not for this Court to determine whether the intention of Congress is logical or beneficial, but rather to interpret the statute consistent with Congress' intent regardless of the desirability of the outcome. *C.I.R. v. Asphalt Products Co., Inc.*, 482 U.S. 117, 121 (1987). The intention of Congress was clear. Unlike the ADA and the Civil Rights Act, FEHBA contains no provision for federal employees to seek extra-contractual damages under the Act. Conversely, Congress determined a preemption provision was necessary to preempt claims arising outside the FEHBA plan.

Saenz further urges that, because an extra-contractual claim may be pursued by a Texas government employee in connection with health benefits under the Texas Employees Uniform Group Insurance Benefit Act, TEX. INS. CODE ANN. § 3.50-2 (West 1981 & Supp. 1996), the FEHBA employee, by analogy, should have a similar right. Pet. 17-18. This argument completely ignores that (1) the Texas system does not have the far reaching control over the employees' benefits which OPM does; (2) a state statute does not need to meet the policy of creating uniformity among different states as the federal statute attempts to do; and (3) most importantly, the state statute does not include a preemption provision. Therefore, this argument is also not persuasive.

Throughout her petition, Saenz attempts to create the impression that, under the interpretation given by the circuit courts directly addressing FEHBA preemption, federal employees have inferior rights to relief compared to those individuals enrolled in group plans in the private sector. The rights and remedies available to a FEHBA participant under a group plan, however, are actually similar to most group plans in the private sector due to the application of ERISA to private sector plans. The Fifth Circuit's decision below is supported by this Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41

(1987), an ERISA case where common law tort and contract claims for benefits under an ERISA-regulated plan were held to be preempted. As noted in *Hayes v. Prudential Life Ins. Co. of America*, "ERISA's preemption clause is similar to § 8902(m)(1) of the FEHBA. [footnote omitted] And the court held that the state claims were preempted despite a savings clause . . . which has no counterpart in the FEHBA." *Hayes*, 819 F.2d at 926. In fact, ultimately, the federal employee arguably ends up with more benefits than an ERISA governed private sector employee because ERISA does not provide the exhaustive regulatory protection that a FEHBA participant receives.

III. FRAUDULENT INDUCEMENT AND BREACH OF FIDUCIARY DUTY CLAIMS ALSO FAIL.

Saenz also seeks reversal as to the fraudulent inducement claim which was held by the Fifth Circuit to be preempted under the authority of *Hayes v. Prudential Ins. Co. of America*, 819 F.2d at 925-26. In further support of preemption of this claim, the Fifth Circuit also cited by analogy, *Hubbard v. Blue Cross and Blue Shield Ass'n.*, 42 F.3d 942, 946-47 (5th Cir.), *cert. denied*, —— U.S. ——, 115 S.Ct. 2276, 132 L.Ed.2d 280 (1995), wherein a fraudulent inducement claim related to an insurer's advertising was held to be preempted under ERISA. Saenz does not even address these cases. Rather, Saenz, in contending the Fifth Circuit erred in finding the fraudulent inducement claim preempted, criticizes the court's reliance on the fact that Humana Health must submit to OPM for prior approval any literature to be distributed at federal facilities to determine if it is in compliance with FEHBA regulations as to misleading, deceptive or unfair advertising. Rec. Vol. 2, pp. 322, 408a & 446. Saenz contends that reviewing material prior to its dissemination does not preclude the possibility of Humana Health not following through with its representations made in a Plan Document. To do so, the petitioner argues, OPM would have to have the ability to perform an audit which, she

claims, "neither FEHBA nor the contract between Humana and OPM make any such provision for that kind of 'audit'." Pet. 24. This is another misstatement of the record by petitioner in that, throughout the contract between OPM and Humana Health, provision was made that OPM had the rights to make audits of the records of Humana Health "as may be necessary to carry out the purpose of the act, regulations and this contract." Rec. Vol. 2, p. 349. Of specific interest is the right of OPM and the General Accounting Office, when conducting audits as required by the FEHBA law, to have access to claims files of federal enrollees and their covered family members. Rec. Vol. 2, p. 359. There is no less than 11 provisions within the agreement between OPM and Humana which allow OPM to audit the files of Humana Health. Therefore, OPM can control the chance of a health plan making a fraudulent representation and, therefore, Saenz's argument on this issue fails.

Regardless, whether claims material can be audited or not is not controlling. As stated in *Hayes v. Prudential Life Ins. Co. of America*, like other extra-contractual claims, permitting a fraud claim would only serve to expand the health plan's obligations and it is, therefore, preempted. *Hayes*, 819 F.2d at 926. The foregoing point raised again by Saenz as to OPM's review of plan material disseminated to government employees, however, demonstrates that a FEHBA participant is not subject to the whim and caprice of the health plan. Congress has empowered OPM to police and protect the participant from precisely the issues raised by Saenz.

The Fifth Circuit did not consider whether a breach of fiduciary duty claim would be preempted as Saenz failed to plead breach of fiduciary duty in the district court. *See Hulsey v. Texas*, 929 F.2d 168, 171 (5th Cir. 1991) (a court of appeals will not consider an issue that was not raised before the district court); *See also Hobbs v. Blackburn*, 752 F.2d 1079, 1083 (5th Cir.), *cert. denied*, 474 U.S. 839 (1985). Therefore, Saenz's urging of reversal

of the fiduciary duty cause of action should not be considered by this Court. Regardless, any such claim has been held to be preempted in the FEHBA context. *See Hayes v. Prudential Life Ins. Co. of America*, 819 F.2d at 926; *Williams v. Blue Cross and Blue Shield of Virginia*, 827 F. Supp. 1228, 1230 (E.D. Va. 1993); *Lieberman v. National Postal Mailhandlers Union*, 819 F. Supp. 344, 348 (S.D.N.Y. 1993); *Bishop v. Continental Ins. Co.*, No. S84-0755 (N.) 1988 U.S. Dist. LEXIS 3244 (S.D. Miss. Jan. 19, 1988).

Additionally, Saenz's reliance upon this Court's ruling in *Varity Corp. v. Howe*, —— U.S. ——, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996) is misplaced. *Varity* involved the application of statutory fiduciary duty obligations created by ERISA. While ERISA and FEHBA are analogous as to the breadth of the "relate to" language of their respective preemption provisions, FEHBA does not contain a breach of fiduciary duty provision such as that found in ERISA. Of course, on the other hand, FEHBA has empowered OPM, as discussed at length before, to exercise authority over the management and administration of government employee health benefits. Under ERISA, no agency has been similarly empowered. Where Congress may have determined there was a need for a statutory fiduciary duty claim in ERISA, it did not find a similar need in FEHBA. In the absence of a statutory provision for such a claim, *Varity* is inapplicable to this FEHBA claim and, for the reasons stated previously, a breach of fiduciary duty claim, if it had been pled, would be preempted.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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